PRINTED: 08/18/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G112	A. BUILDING _____ B. WING _____	08/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHOLISTIC 02	1226 LAWRENCE STREET, NE WASHINGTON, DC 20017

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W 000	INITIAL COMMENTS An recertification survey was conducted from August 10, 2010, through August 13, 2010, utilizing the fundamental survey process. A random sampling of four clients was selected from a population of seven males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with clients and staff, and the review of clinical and administrative records, including incident reports.	W 000	Received 8/31/10 DOH-HRLA-ICFD	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to implement its policies to ensure the health and safety for one of seven clients residing in the facility. (Clients #6) The finding includes: The facility failed to implement it's policy for investigating serious reportable incidents (neglect) as evidence below: On August 11, 2010, beginning at 12:45 p.m., review of the unusual incident reports revealed an incident dated June 29, 2009. According to the incident, the facility's qualified mental retardation professional (QMRP) received a phone call at approximately 12:50 p.m., from a resident of	W 149	8/15/10 This incident was determined by wholistic IMC and DDA IMEH As a reportable event. Nonetheless, an investigation has been completed. Please be advised that the Day Program has been uncooperative & thus a qualitative investigation was not done. Client # 4 no longer attends	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
M. Estelle Jones	Vice President	8/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1	W 149	this program.	

Maryland informing the QMRP that Client #6 was with his group at a local park in Maryland. The resident mentioned that Client #6 wondered into his picnic group while at the park. The QMRP informed the resident that Client #6 was on a community outing with his day program and that they must have left him behind. The QMRP immediately called the day program and informed them that Client #6 was left behind at the park. The day program called their day program staff and informed them that Client #6 was still at the park. Minutes later, the day program called the QMRP back to inform him that Client #6 was back with the day program staff. Further review of the incident revealed a head to head assessment was completed by the nurse upon arrival to his home. The client was alert, cheerful, and in good spirits. There was no change in his behavior.

Interview with the QMRP on August 11, 2010, at approximately 1:30 p.m., revealed that the incident dated June 29, 2009, was cited as neglect according to the local agency. Further interview with the QMRP revealed that this incident was classified as a serious reportable incident. When asked if the facility had conducted an internal investigation, the QMRP stated that he was unsure and would follow up with the incident management coordinator.

Interview with the facility's Incident Management Coordinator (IMC) on August 13, 2010, at approximately 9:30 a.m., revealed that an internal investigation report was not conducted for the June 29, 2009 incident.

Review of the facility's "Policy for Investigation of Serious Reportable" incidents conducted on August 11, 2010, at approximately 2:45 p.m.,

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W 149	Continued From page 2 revealed all serious reportable incidents will be investigated by the facility beginning within 12 hours after the incident had occurred. Further review of the policy revealed that immediately upon receiving any report of person mistreatment, neglect or abuse, the IMC would conduct an investigation.	W 149		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services for two of the seven clients residing in the facility. (Client #4 and #5) The findings include: 1. [Cross refer to W252]. The QMRP failed to ensure that each staff was effectively trained to document Client #4's maladaptive behavior in measurable terms. 2. [Cross refer to W192]. The QMRP failed to ensure that each staff was effectively trained to accurately implement Client #5's pureed diet.	W 159	See W252 See W192	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.	W 192		

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W 192	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each staff was effectively trained to address the health care needs of one of seven clients in the facility. [Client #5 residing in the facility) The finding includes: 1. The facility failed to ensure that staff training was effective for the accurate implementation of Client #5's pureed diet, as evidenced below: a. On 8/10/2010, at 5:26 p.m., a direct support staff was observed preparing pureed whole wheat bread in the food processor. During this time, an unmeasured amount hot water was poured on the bread in the food processor, then the bread was ground to a thin pureed texture. A few minutes later, at 5:28 p.m., interview with the staff preparing the food revealed that the bread was for Client #5. Further discussion with the staff on 8/11/2010, at 4:17 p.m., indicated that the client required his bread to be thinly pureed and lump free to prevent him from coughing. Interview with the qualified mental retardation professional (QMRP) on 8/12/2010, at 5:17 p.m., indicated staff had been trained on the client's mealtime protocol. Record review on 8/11/10, at 1:50 p.m., revealed that Client #5 was prescribed a pureed a high fiber, pureed diet. The mealtime protocol dated May 2010 stated that the client should be provided a "Dysphagia Diet 1: Pureed diet texture (pudding-consistency with no lumps). Regular liquids." Further record review on 8/13/10, at approximately 12:45 p.m., revealed a Speech and	W 192	Staff have been re-trained on how to prepare pureed diet. Please find attached directives on how pureed diet should be prepared.	8/30/10

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W 192	Continued From page 4 Language Pathologist training agenda (dated March 3, 2010) which included mealtime guidelines (food/liquid textures). Interview with the QMRP indicated that specific guidelines on how to prepare each pureed food to the prescribed consistency had become detached and were not available. At the time of the survey, there was no evidence that each staff had been trained to accurately implement Client #5's pureed diet.	W 192		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure consistent documentation of progress on the Individual Program Plan (IPP) objective, for one of four clients in the sample. (Client #4) The finding includes: The facility failed to provide evidence that data was consistently maintained on Client #4's training objective designed to improve his behavior, as evidenced below: a. Observation of Client #4 on August 10, 2010, at 5:52 p.m., revealed he refused to stand upright as two staff walked him toward the bathroom located on the first floor. Staff then allowed him to sit on the floor. He was verbally prompted to	W 252	Staff have been in-serviced on Client # 4's behavior support plan and documenting all behaviors on the ABC data sheet. 8/26/10 8/26/10	

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W 252	Continued From page 5	W 252		

get up, however when he refused to get up independently, he was assisted by staff to stand. Staff escorted him to the kitchen sink where he was provided assistance to wash his hands. The client then sat back on the floor, then after repeated verbal prompts from the staff got up to a squatting position where he remained until 6:05 p.m. At that time, he was observed walking in a squatting position in the hallway.

Observation on August 10, 2010, at 6:49 p.m., revealed he sat on the sidewalk. He was encouraged and assisted by staff to get up from the ground, however sat back on the ground again.

Interview with staff on August 10, 2010, at 6:05 p.m. revealed Client #4's sitting on the floor/ground and refusing to stand was one of his targeted behaviors, which should be documented in his record. Interview with QMRP on August 12, 2010, at 2:14 p.m. indicated that although the record suggested an increase in the behavior over recent months, the increase was likely due to improved documentation of the behavior.

Record review on August 13, 2010 at 12:02 p.m., revealed a goal to improve the client social behavioral skills. The objective stated that the client "will decrease incidents of refusing to stand up to zero incidents per month for 12 consecutive months. Further record review on August 13, 2010 revealed, the "refusing to stand behavior" on August 10, 2010, which were observed to occur in the kitchen and on the sidewalk, had not been documented.

At the time of the survey, there was no evidence that the facility ensured documentation or the

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W 252	Continued From page 6 client's aforementioned targeted behavior to ensure accurate monitoring of the individual program plan objective.	W 252		

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I 000	INITIAL COMMENTS An relicensure survey was conducted from August 10, 2010, through August 13, 2010. A random sampling of four residents was selected from a population of seven males with various levels of mental retardation and disabilities. The findings of the survey were based on observations at the group home and three day programs, interviews with residents and staff, and the review of clinical and administrative records, including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the interior and the exterior of the GHMRP was maintained in a safe, orderly, and attractive manner, for seven of seven residents residing in the facility. (Residents #1, #2, #3 , #4, #5, #6, and #7) The findings include: An inspection of the environment was conducted on August 11, 2010, beginning at 10:15 a.m. During the inspection, the surveyor was accompanied by the house manager (HM) and maintenance staff person. The following concerns were identified:	I 090		

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I 090	Continued From page 1 Interior: 1. The treads of the stairs leading from the first to the second floor were stained and soiled.	I 090	Stairs have been cleaned	8/30/10
	2. The bathroom on the second floor (right side) had no cup holder or dispenser for cups. (This deficiency was eliminated prior to the surveyor's departure from the facility on August 11, 2010.		Cups have been placed in dispenser	8/14/10
	3. In bedroom #3, there was torn wall paper on the right corner of the ceiling.		Wall paper has been repaired	8/14/10
	4. In the linen closet ceiling, there was chipping and peeling paint.		Paint has been stripped and new coat applied	8/30/10
	5. The kitchen oven had grease on the inside.		Oven has been cleaned	8/17/10
	6. In the dining room, the carpet under the table was raveled and torn, which created a potential trip hazard.		Dining Room rug has been removed	8/14/10
	Exterior: 7. Several cracks were observed in the driveway, which created a potential trip hazard.		Cracks in driveway have been filled	8/30/10
	8. There was a piece missing from the awning above the rear door.		Awning has been replaced	8/30/10
	These deficiencies were acknowledged by the house (HM) at approximately 11:45 a.m. on August 11, 2010.			
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans.	I 180		

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I 180	Continued From page 2 This Statute is not met as evidenced by: Based on interview, and record review, the GHMRP failed to ensure that the Qualified Mental Retardation Professional (QMRP) coordinated services for two of the seven residents residing in the GHMRP. (Resident #4 and #5) The finding includes: 1. [Cross refer to W252]. The QMRP failed to ensure that each staff was effectively trained to document Resident #4's maladaptive behavior in measurable terms. 2. [Cross refer to W192]. The QMRP failed to ensure that each staff was effectively trained to accurately implement Resident #5's pureed diet.	I 180	See W252 See W192	
I 222	3510.3 STAFF TRAINING There shall be continuous, ongoing in-service training programs scheduled for all personnel. This Statute is not met as evidenced by: Based on observation, interview and record review, the group home for mentally retarded persons (GHMRP) failed to ensure a continuing training program for staff to addressed the needs of two of seven residents residing in the GHMRP. (Residents #4 and #5) The findings include: 1. The GHMRP failed to ensure that staff training was effective for the accurate implementation of Resident #5's pureed diet, as evidenced below: a. On 8/10/2010 at 5:26 p.m., a direct support staff was observed preparing pureed whole wheat	I 222	See W252 See W192	

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I 222	Continued From page 3 bread in the food processor. During this time, an unmeasured amount hot water was poured on the bread in the food processor, then the bread was ground to a thin pureed texture. A few minutes later, at 5:28 p.m., interview with the staff preparing the food revealed that the bread was for Resident #5. Further discussion with the staff on 8/11/2010, at 4:17 p.m., indicated that the resident required his bread to be thinly pureed and lump free to prevent him from coughing. Interview with the qualified mental retardation professional (QMRP) on 8/12/2010, at 5:17 p.m. indicated staff had been trained on the resident's mealtime protocol. Record review on 8/11/10, at 1:50 p.m., revealed that Resident #5 was prescribed a pureed, high fiber diet. The mealtime protocol dated May 2010 stated that the resident should be provided a "Dysphagia Diet 1: Pureed diet texture (pudding-consistency with no lumps). Regular liquids." Further record review on 8/13/10, at approximately 12:45 p.m., revealed a Speech and Language Pathologist training agenda (dated March 3, 2010) which included mealtime guidelines (food/liquid textures). Interview with the QMRP indicated that specific guidelines on how to prepare each pureed food to the prescribed consistency had become detached and were not available. At the time of the survey, there was no evidence that each staff had been trained to accurately implement Resident #5's pureed diet. 2. The GHMRP failed to ensure that each staff was effectively trained to accurately collect data on Resident #4 behavioral objectives as evidenced below:	I 222		

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I 222	Continued From page 4	I 222		

a. Observation of Resident #4 on August 10, 2010, at 5:52 p.m., revealed he refused to stand upright as two staff walked him toward the bathroom located on the first floor. Staff then allowed him to sit on the floor. He was verbally prompted to get up, however when he refused to get up independently, he was assisted by staff to stand. Staff escorted him to the kitchen sink where he was provided assistance to wash his hands. The resident then sat back on the floor, then after repeated verbal prompts from the staff got up to a squatting position where he remained until 6:05 p.m. At that time, he was observed walking in a squatting position in the hallway.

Observation on August 10, 2010, at 6:05 p.m., revealed he sat on the ground on the side walk. He was encouraged and assisted by staff to get up from the ground, however sat back on the ground again.

Interview with staff on August 10, 2010, at 6:05 p.m., revealed Resident #4's sitting on the floor/ground and refusing to stand was one of his targeted behaviors, which should be documented in his record. Interview with QMRP on August 12, 2010, at 2:14 p.m., indicated that although the record suggested an increase in the behavior over recent months, the increase was likely due to improved documentation of the behavior.

Record review on August 13, 2010, at 12:02 p.m., revealed a goal to improve the client social behavioral skills. The objective stated that the client "will decrease incidents of refusing to stand up to zero incidents per month for 12 consecutive months. Further record review on August 13, 2010 revealed the "refusing to stand behavior" on August 10, 2010, which were observed to occur

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I 222	Continued From page 5 in the kitchen and on the sidewalk, had not been documented. At the time of the survey, there was no evidence that the facility ensured documentation or the client's aforementioned targeted behavior to ensure accurate monitoring of the individual program plan objective.	I 222		